Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CLARITA LITTLES, MD
PO BOX 121589
ARLINGTON TX 76012

Respondent Name

INSURANCE CO OF THE STATE OF PA

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-10-4560-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Not paid per the DWC Fee Guides"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Carrier was notified of MFDR dispute on July 02, 2010 and no carrier response to MFDR was received.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 06, 2009	97546-W8-RE	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated December 07, 2009
   - W1 – Workers Compensation State Fee Schedule Adjustment

Explanation of benefits dated January 28, 2010
- W1 – Workers Compensation State Fee Schedule Adjustment

Explanation of benefits dated April 29, 2010
- W1 – Workers Compensation State Fee Schedule Adjustment

Issues

1. Did the Requestor bill for a Return to Work evaluation as requested by the Division?
2. Was the MAR for documented services paid appropriately and is the Requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204(i) and (k), the Requestor has billed for a Return to Work evaluation as requested in accordance with the EES-14 form.
2. Review of the submitted documentation finds that the Requestor billed correctly and documented appropriately the services rendered and is due the full MAR of $500.00 for the Return to Work evaluation. As the Respondent only reimbursed $350.00 for CPT code 99456-W8-RE, the Requestor is due an additional $150.00 per 28 Texas Administrative Code §134.204 (i) and (k).

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 20,2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.